

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Revised Report after IDR disputing F329. F329 removed from report. An unannounced annual survey and complaint visit was conducted at the facility from December 9, 2009 through December 22, 2009. The facility census on the first day of survey was one hundred and ten (110). The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included forty-eight (48) residents.	F 000	The facility provides the following Plan of Correction without admitting or denying the validity of the existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one (R81) out of 48 sampled residents received reasonable accommodations of their individual needs. Findings include: On 12/10/09 at approximately 1 PM, R81 was observed in her wheelchair in her room with the call bell clipped on the bedspread. The surveyor asked the resident how the resident was doing	F 246	F-246 483.15(e)(1) Accommodation of needs Resident #81 remains in the center and has her call bell within reach when out of bed in her wheelchair. Current residents have been observed when out of bed in their chairs to determine that call bells are within reach. In-servicing shall be completed on or before 2/20/10 for nursing staff on resident rights related to call bell placement. Random rounds shall be completed weekly to determine compliance. This shall be the responsibility of the DON or designee. The DON shall report monthly to the Administrator and the QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/20/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
James M. Adams, LNHA

TITLE
Administrator

(X6) DATE
2/2/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 246	Continued From page 1 and the resident replied that she wanted to get back into the bed. The surveyor asked the resident to use the call bell to alert the staff for assistance, however, the resident reported that she was not able to reach the call bell. Subsequently, the surveyor reported this to the unit manager (E9). Follow-up interview with E6 on 12/10/09 at approximately 1:25 PM revealed that R81 does not self propel her wheelchair, thus, would not have been able to maneuver to reach the call bell without assistance.	F 246	F-272 483.20, 483.20(b) Comprehensive Assessments		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	Residents #228 remains in the center. The resident has been reviewed by the ICP team and her plan of care reflects her current level of care. The resident has had a significant correction MDS completed. Current residents shall have their MDS reviewed for accuracy prior to her next care conference meeting. In-servicing shall be completed for any staff member completing sections of the MDS on accuracy on or before 2/20/10. Random audits shall be completed weekly over the next 90 days to determine compliance; this shall be the responsibility of the DON or designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.		2/20/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page 2 Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based upon observation, record review and interview, it was determined that the facility failed to provide an initial comprehensive assessment that accurately reflected one resident's (R228) functional capacity out of 48 sampled residents. Findings include: R228 was admitted to the facility 11/19/09 with Rheumatoid Arthritis. On 12/10/09, an observation of R228, seated in a wheelchair, revealed that R228 had limited use of her upper extremities. Additionally, R228 stated that she couldn't raise her arms too much because they were stiff. Review of the initial Physical Therapy evaluation, dated 11/20/09, revealed that R228 had impaired functional range of motion (ROM) in both upper extremities and the left lower extremity. On 12/19/09, during an interview with the Director of Occupational Therapy (E6), she confirmed that R228 was receiving Occupational Therapy services to address upper body ROM limitations. The facility failed to accurately code the admission Minimum Data Set Assessment (MDS), dated 11/24/09, when it coded R228 as having no limitation in ROM. Findings were confirmed with the RN Assessment Coordinator (E7).	F 272			
F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279 SS=D	<p>Continued From page 3 CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop care plans to meet residents' medical and nursing needs based on their comprehensive assessments for 3 residents (R 156, R210 and R223) out of 48 sampled residents. Findings include:</p> <p>1. R223 was admitted to the facility on 11/5/09 with diagnoses including Multiple Sclerosis. Upon admission, R223 was on Celexa, an antidepressant, for depression.</p>	F 279	<p>F-279 483.20(d), 483.20(k)(1) Comprehensive Care Plans</p> <p>Residents #156, #210 and 223 have been discharged from the center. Current residents shall have their plan of care reviewed at the next care conference to determine that their current level of care is addressed.</p> <p>In-servicing shall be completed for facility staff completing care plans on developing care plans or before 2/20/10.</p> <p>Random audits shall be completed weekly for the next 90 days of resident care plans to determine compliance. This shall be the responsibility of the DON or designee.</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	2/20/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 4</p> <p>Review of the the admission Minimum Data Set (MDS), dated 11/12/09, revealed that R223 had insomnia, sadness and reduced social interaction. A Medicare MDS, dated 11/15/09, revealed that R223 had increased behavioral symptoms including crying, unpleasantness in the morning, withdrawn and reduced social interaction.</p> <p>The facility failed to develop a care plan for depression/behavioral symptoms despite R223 being on antidepressant therapy and having increased behavioral symptoms. On 12/21/09, findings were confirmed with the Social Worker (E8).</p> <p>2. R210 was admitted to the facility on 9/17/09 with diagnoses including an accident that resulted in fractures of the nose and left elbow/arm, anemia, diabetes, and coronary artery disease (CAD).</p> <p>R210 was on Aspirin and Plavix daily for anticoagulation. These medications were used to thin the blood/prevent blood clots related to R210's coronary artery disease. Additionally, R210's physician ordered blood tests for Hemoglobin (a protein used by red blood cells to distribute oxygen to tissues in the body) and Hematocrit (the percent of blood that is occupied by red blood cells) weekly due to R210's anemia.</p> <p>The facility failed to develop a care plan for R210 who was at risk for bleeding and bruising due to administration of Aspirin and Plavix, anticoagulation therapy.</p> <p>3. R156 was admitted to the facility on 11/16/09 with an indwelling catheter.</p>	F 279			

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 Review of R156's clinical record revealed that the resident's indwelling catheter was left in place until 12/11/09 due to excoriation (irritation) of the perineal area. R156's clinical record lacked a care plan for the use of an indwelling catheter. In an interview with the unit manager (E9) on 12/17/09, she confirmed that there was no care plan for catheter use for R156 and that one should have been created.	F 279	F-280 483.20(d)(3), 483.10 (k)(2) Comprehensive Care Plans Resident's #58 remains in the center, and has been reviewed by the ICP team and changes have been made to the plan of care on 12/17/09 to reflect the following: <ul style="list-style-type: none">• Discontinuation of weights• The word "Norton" was changed to "Braden"• Added a problem related to risks from use of aspirin and plavix.	2/20/10
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that	F 280	Current residents shall be reviewed at their next care conference to determine the accuracy of their care plans. In-servicing shall be completed for staff developing and updating care plans on the development of care plans on or before 2/20/10. Random audits shall be completed weekly over the next 90 days to determine compliance. This shall be the responsibility of the DON or designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 6 the care plan was reviewed and revised for one resident (R58) out of 48 sampled residents. Findings include: R58 was admitted to the facility in 2004. R58 had diagnoses including stroke with left sided weakness and difficulty swallowing, high blood pressure, neurogenic bladder with urinary incontinence, diabetes and dementia. The facility failed to revise the following care plans, last reviewed on 9/26/09: 1. On 4/3/09, R58's physician ordered weights to be discontinued. R58's physician ordered lab work to be discontinued as of 8/6/09. The "Nutrition" Care Plan failed to be revised to reflect discontinuance of weights and lab work for R58; 2. The facility discontinued use of the Norton Pressure Ulcer scale as of 7/09. The "Actual Skin Breakdown" Care Plan for R58 failed to be revised to reflect that the Braden not the Norton Pressure Ulcer scale was being used; 3. The "At risk for Bruising/skin tears as evidenced by frail, fragile skin" Care Plan failed to be revised to include that R58 was at risk for bleeding and bruising due to anticoagulation with Plavix and ASA therapy. On 12/17/09, the findings were confirmed by the Unit Manager (E4).	F 280			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID / PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary care and services for one (R158) out of 48 sampled residents. Findings include: Review of R158's physician's order, dated 11/10/09, revealed an order for Claritin 10 mg. (milligram) by mouth for a period of 30 days and and ProAir HFA MDI (multi dose inhaler) two puffs twice a day for 30 days. Review of the December 2009 Medication Administration Record noted Claritin was discontinued after the 30 days on 12/10/09. In addition, ProAir was administered on 12/11/09, 12/12/09, and 12/13/09, however, there was no order to continue the inhaler after the 30 days. An interview with the unit manager (E4) on 12/14/09 at approximately 4 PM confirmed that there was no order to continue the ProAir.	F 309	F-309 483.25 Quality of Care Resident #158 remains in the center and continues to receive prescribed medications according to the physician orders. Claritin and ProAir were discontinued and have not be administrated since 12/13/09. Current residents have had their orders reviewed to determine appropriate administration of medications. In-servicing shall be completed on or before 2/20/10 for licensed nursing staff on medication administration. Random audits shall be completed weekly over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/20/10	
F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review it was determined that the facility failed to provide special eating equipment/utensils for one resident (R5) who needed them out of 48 sampled residents. Findings include: R5 was admitted to the facility in 1992. Diagnoses	F 369			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 369	Continued From page 8 included severe degenerative joint disease and obesity. R5 was observed eating her lunch meals in bed as was R5's preference on 12/9, 12/10, 12/11 and 12/15/09. However, R5 had difficulty holding and using her fork. On 12/9/09, R5 stated that she had arthritis in her hands and sometimes she had trouble holding the utensils. She then began to eat her salad grasping a cucumber and a tomato with her fingers. Additionally, R5 stated that she had to eat her spaghetti noodles with her fingers because it was too hard to hold and use the fork. On 12/10/09, the Unit Manager (E4) accompanied the surveyor to R5's room at lunchtime. E4 confirmed that R5 was having difficulty using her fork and E4 stated that she would obtain a physician's order for an evaluation for adaptive utensils.	F 369	F-369 483.35(g) Dietary Services -- Assistive Devices Residents #5 has expired. Prior to the resident expiring the resident was evaluated for the need of adaptive equipment. The resident refused any adaptive equipment. Current residents identified with any contractures of the hands have been assessed for the need of adaptive equipment and equipment has been provided. In-servicing shall be provided for the nursing staff on adaptive equipment on or before 2/20/10. Random rounds shall be completed weekly for the next 90 days to determine compliance with pressure ulcer documentation. This shall be the responsibility of the DON or designee.	2/20/10	
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations of the clean pots and pans shelf in the kitchen on 12/15/09, it was	F 371	The DON shall report to the QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the date and provide recommendations to obtain and maintain compliance		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page 9 determined that the facility failed to store food preparation equipment under sanitary conditions. Findings include: 1. Three out of seven steam table pans observed had food debris and grease on food contact surfaces and non-contact surfaces respectively. These pans were stacked on the shelf in ready-to-use status.	F 371	F-371 483.35(i) Sanitary Conditions All steam table pans have been cleaned. In-servicing shall be completed on or before 2/20/10 for dietary staff on proper pan washing.		2/10/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that during the monthly drug regimen review the irregularities and lack of monitoring were reported to the attending physician for one (R158) out of 48 sampled residents. Findings include: Cross refer F329. Review of R158's December, 2009 monthly physician's order sheet (POS) noted that R158 was receiving Simvastatin 20 mg. daily. Record review revealed that the last lipid panel was done in May 2009.	F 428	Audits shall be completed weekly over the next 90 days to determine compliance; this shall be the responsibility of the Food Service Director. The Food Service Director shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2009
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	Continued From page 10 The facility failed to ensure that the lack of monitoring of a lipid panel for R158 was reported to the physician. There was no recent lipid panel during the monthly drug regimen. On 12/14/09 at approximately 4 PM, findings were confirmed during an interview with the unit manager (E4). On 12/15/09 at approximately 2 PM, an interview with the licensed pharmacist (E5) revealed that his recommendation would have been for the monitoring of lipid panel and liver function test every 6 months. E5 stated that he thought that the laboratory results were ordered when R158 was recently hospitalized. Additional record review revealed that no testing for lipid panel or liver function was completed during the December 2009 hospitalization.	F 428	F-428 483.60(c) Drug Regimen Review Resident #158 remains in the center and has been assessed by the primary care physician for the need for labs related to the medication. At this time the physician has opted not to have any test completed. Current residents returning from the hospital or that have a change in medication dose shall be evaluated by the consultant pharmacist for recommendation for lab studies. Nursing shall communicate with the physician the recommendations. In-servicing shall be completed for licensed nurses on recommended lab studies on or before 2/20/10. Random audits shall be completed weekly over the next 90 days to determine compliance. This shall be the responsibility of the DON or designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/20/10	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection
JAN 26 2010
Director's Office

STATE SURVEY REPORT

Page 1 of 4

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: December 22, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Revised report 1/20/2010 after IDR request. F329 deleted.</p> <p>An unannounced annual survey and complaint visit was conducted at the facility from December 9, 2009 through December 22, 2009. The facility census on the first day of survey was one hundred and ten (110). The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included forty-eight (48) residents.</p> <p>Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Services to Residents:</p> <p>General Services:</p> <p>The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and</p>	<p>The facility provides the following Plan of Correction without admitting or denying the validity of the existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.</p> <p><i>3201.6.1.1 -General Services</i></p> <p>Cross-refer to CMS 2567-L survey report date completed 12/22/09, F371, F309 and F428</p>
3201		
3201.6.0		
3201.6.1.1		



DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

Division of Long Term Care
Residents' Protection

STATE SURVEY REPORT

Page 2 of 4

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: December 22, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>general well-being.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 12/22/09, F246, F309, F369 and F428.</p> <p>Nursing Administration</p> <p>A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L, survey date completed 12/22/09, F279.</p> <p>The assessment and care plan for each resident shall be reviewed/revised as needed when a</p>	<p>3201.6.5.6 – Nursing Administration</p> <p>Cross-refer to CMS 2567-L survey report date completed 12/22/09, F279</p> <p>3201.6.5.7 – Nursing Administration</p> <p>Cross-refer to CMS 2567-L survey report date completed 12/22/09, F272 and F280.</p>
3201.6.5		
3201.6.5.6		
3201.6.5.7		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLICRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 3 of 4

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: December 22, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.5	significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 12/22/09, F272 and F280. Kitchen and Food Storage Areas:	<i>3201.7.5 – Kitchen and Food Storage Areas</i>
3201.7.5.1	Facilities shall comply with the Delaware Food Code 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue and	Cross-refer to CMS 2567-L survey report date completed 12/22/09, F371



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 4 of 4

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: December 22, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>other debris.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 12/22/09, F371.</p>	